BUREAU OF SPECIAL HEALTH CARE NEEDS

Report of External Concern/Complaint

CONFIDENTIAL

Date Received: _____

Received by: _____ Program Name: _____ Program Number: ____

Section I. Concern/Statement of Problem _____ Attachment __ Yes __ No # pages ___

A. Place a check at the letter reflecting the appropriate party contacting you with a concern.

A __ Participant Concern
B __ Family Concern
C __ Provider Concern
D __ Bureau Chief Concern
E __ AO Coord. Concern
F __ BSHCN Staff Concern
G __ Pgm Mgr Concern
H __ DOH Concern _____
Division (Specify) _____
I __ Regulatory Agency Concern
J __ Contracting Agency Concern
K __ Advisory Council (Specify) _____
L __ Elected Official Concern
M __ Other (Specify)_____

B. Place a check at the appropriate number of the identified concern or potential concern.

1 __ Participant at Risk
2 __ Services Provided
3 __ Lack of Services Provided
4 __ Billing Issue
5 __ Payment Problem
6 __ Participant Eligibility
7 __ Provider Eligibility
8 __ Medical Treatment Issue
9 __ Provider Issue
10 __ Personnel Issue
11 __ Hardware/Software Issue
12 __ Information/Data Issue
13 __ Phone System
14 __ Environmental Safety
15 __ Other (Specify)_____

Section II. Summary Information:

On the lines below, provide a summary of the concern/complaint. Provide information to assist appropriate follow-up. Include name, title, telephone number and any pertinent or identifying information (such as DCN, SSN or Vendor #) that will be helpful to resolving the issue. Include any pertinent historical facts or other parties involved. DCN#_____
Attach additional pages or other documentation as appropriate. Vendor/ SSN#_____

_____
_____
_____
_____
_____
_____
_____

Section III. Action Taken and Recommendations:

Briefly describe any actions taken to assist in resolution. Identify contacts made with name, title, telephone number, dates and times of contacts, if appropriate.

_____
_____
_____
_____
_____
_____
_____

Written Response required: __Yes __No To whom? (Be specific)_____
Phone Response required: __Yes __No To whom? (Be specific)_____
Signature of Party completing the above information_____Date _____

Section IV. Investigative Summary and Plan of Action. Briefly describe details of planned or current action necessary to resolve issue. Include name, title, and telephone number of person(s) contacted, dates and times of contact, if appropriate.

_____
_____
_____
_____
_____
_____
_____

Date Resolved:_____

Area Office Coordinator/Program Manager Signature_____ Date_____

Bureau Chief Signature _____ Date_____

Form received, logged and filed: _____ Initials____